



G Shaheed, M.D.
 11795 Education Street, STE 220
 Auburn, CA 95602
 Ph: 530-888-9907 Fax: 530-886-6888

PATIENT REGISTRATION

PATIENT NAME LAST FIRST	TODAY'S DATE:
MAILING ADDRESS	HOME PHONE
CITY STATE ZIP	WORK PHONE
DATE OF BIRTH SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER
REFERRING PHYSICIAN	
PATIENT EMPLOYER	OCCUPATION
EMPLOYER ADDRESS CITY STATE ZIP	PHONE

BILLING INFORMATION/RESPONSIBLE PARTY (Complete if person responsible is other than the patient)

NAME LAST FIRST	DATE OF BIRTH	RELATIONSHIP
RESPONSIBLE PARTY'S EMPLOYER		SOCIAL SECURITY NUMBER
ADDRESS CITY STATE ZIP	PHONE	

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME	RELATIONSHIP
ADDRESS CITY STATE ZIP	PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE		
SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE	ID NUMBER	GROUP NUMBER
SECONDARY INSURANCE		
SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE	ID NUMBER	GROUP NUMBER

ASSIGNMENT OF BENEFITS -- CONSENT FOR TREATMENT -- RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and any other plan to Northcal Hematology Oncology inc./Gurvinder Shaheed, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am responsible for all charges wether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I hereby authorize Northcal Hematology Oncology inc./Gurvinder Shaheed, M.D. to perform any medical treatment deemed necessary.

PATIENT SIGNATURE	INSURED'S SIGNATURE
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Consent to Release Information to Family Members and/or Friends

With the increasing awareness of a patient's right to confidentiality, we are asking all of our patients to complete this form. It will give the doctors and staff guidance as to who should be allowed to receive information about your healthcare.

Please complete one of the three options listed.

1. _____ DO NOT discuss my medical condition with anyone. If you choose this option stop here, then sign and date at the bottom.
2. _____ No restrictions (may discuss with anyone). If you choose this option stop here, then sign and date at the bottom.
3. _____ I, _____, give the physicians and office staff of Northcal Hematology Oncology Inc. permission to discuss my medical condition with the following individuals:

With: _____

Who is: _____ Phone Number: _____
Relationship to Patient

And/Or: _____

Who is: _____ Phone Number: _____
Relationship to Patient

And/Or: _____

Who is: _____ Phone Number: _____
Relationship to Patient

And/Or: _____

Who is: _____ Phone Number: _____
Relationship to Patient

This consent is in force indefinitely unless you fill in an expiration date or you revoke your consent in writing.

Patient Signature

Date

Consent expiration date (if any) _____

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND
CONSENT FORM
NORTHCAL HEMATOLOGY ONCOLOGY INC.
11795 EDUCATION STREET, STE 220
AUBURN, CA 95602**

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis.

I have received, read and understand you *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has right to change its *Notice of Privacy Practices* from time to and that I may contact this organization at any time at the above address to obtain a copy of the current *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____ Date: _____

Witness: _____

Health Questionnaire

(Please complete fully)

Name: _____

DOB: _____

Please list medications taken regularly, including over-the-counter and non-prescription products:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any allergies to medication: _____

Please list all chronic medical problems, past and present: _____

_____	_____
_____	_____
_____	_____
_____	_____

Please list all surgeries, including year:

_____	_____
_____	_____
_____	_____

Have any of your blood relatives ever been diagnosed as having Cancer or blood disorders?

Relationship to yourself

Type of Cancer

_____	_____
_____	_____
_____	_____
_____	_____

Do you currently smoke? N Y _____ Packs per day _____ Years

Have you ever smoked? N Y Date quit: _____

Do you drink alcoholic beverages? ___Never ___Rarely ___Moderately ___Daily

What is/was your usual occupation? _____

Are you: Single Married Widowed Divorced Significant Other

Please list other doctors involved in your healthcare: _____

Systemic Review

General:

Excessive Sweating	N	Y
Fever/Chills	N	Y
Itching/Rash	N	Y
Mouth Sores	N	Y
Recent Weight Change	N	Y
Tiredness	N	Y
Other:	_____	

Head, Eyes, Ears, Nose, Throat, & Neck:

Dizziness	N	Y
Hard of Hearing	N	Y
Headaches	N	Y
Seizures	N	Y
Thyroid Problems	N	Y
Visual Changes	N	Y
Other:	_____	

Respiratory:

Asthma/Wheezing	N	Y
Difficulty Breathing	N	Y
Pleurisy/Pneumonia	N	Y
Spitting up blood	N	Y
Other:	_____	

Cardiovascular:

Chest pain/Angina	N	Y
Difficulty walking (2 blocks)	N	Y
Heart Arrhythmia	N	Y
High Blood Pressure	N	Y
Heart Murmur	N	Y
Heart problems/attacks	N	Y
Shortness of Breath	N	Y
Swelling of hands and/or feet	N	Y
Other:	_____	

Hematological:

Bleeding tendencies	N	Y
Blood disease	N	Y
Nosebleeds	N	Y
Other:	_____	

Gastrointestinal:

Bleeding w/ bowel movements	N	Y
Constipation	N	Y
Cramping/pain in abdomen	N	Y
Dark stools	N	Y
Diarrhea	N	Y
Difficulty Swallowing	N	Y
Does food stick in your throat?	N	Y
Heartburn	N	Y
Hemorrhoids	N	Y
Nausea/Vomiting	N	Y
Painful bowel movements	N	Y
Recent change in bowel habits	N	Y
Vomiting blood	N	Y
Other:	_____	

Genitourinary:

Blood in urine	N	Y
Burning/painful urination	N	Y
Frequent urination	N	Y
Kidney problems	N	Y
Other:	_____	

Locomotor-Musculoskeletal:

Arthritis	N	Y
Back Pain	N	Y
Bone Pain	N	Y
Joint Pain	N	Y
Joint Swelling	N	Y
Muscle Weakness	N	Y
Phlebitis	N	Y
Stroke-like Symptoms	N	Y
Varicose veins	N	Y
Other:	_____	

Neuro/Psychiatric:

Convulsions	N	Y
Fainting spells	N	Y
Loss of Consciousness	N	Y
Numbness/Tingling	N	Y
Prior psychiatric history	N	Y
Explain:	_____	

Gynecological:

Last Menstrual Period: _____